

No. 2  
12-45  
-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43056**  
Registrar's No. **10745**

FILED DEC 23 1946 **318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Firmin Desloge Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5710 West Park Ave  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) \_\_\_\_\_  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Della Mae Valleroy

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 12 2 46  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
—	—	11	hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name George Daniel Valleroy

13. Birthplace Madoc Ill.  
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Rachel Cheek

15. Birthplace Granite City Ill.  
(City, town, or county) (State or foreign country)

16. (a) Informant Geo. Valleroy

(b) Address 5710 West Park Ave

17. (a) Burial (b) Date thereof 12-16-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial Graceland Cem. Rte. 211

18. (a) Signature of funeral director Louis H. Bopp, Inc.

(b) Address 1 E. Kentucky Mo.

19. (a) DEC 16 1946 J. F. Bredebeck  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 12 day 13  
year 46 hour 12 minute 27 P. M.

21. I hereby certify that I attended the deceased from 12 Dec  
1946, to 13 Dec 1946

that I last saw her alive on 13 Dec  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Approximately 7 mos. ago.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury

23. Signature D. L. ...  
Address 1325 So. Grand Date signed 16 Dec 46

FORM 45

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Peter B. Dubouillet

Licensed Embalmer No. 3691

P. O. Address Richmond High

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.